PHYSICIAN/HEALTH PROFESSIONAL VERIFICATION OF LIVE-IN AIDE

To: (Name & address)
_____
_____
_____

Date_____

Phone #_____
Fax #_____

Applicant/Participant Name: _____ Social Security #: _____

The individual named directly above is an applicant/tenant of the Federal Housing Tax Credit Program. Federal regulations require that we must verify income in order that the anticipated gross income for the next twelve months may be calculated. The information provided will remain confidential to satisfaction of that stated purpose only. Your prompt response is crucial and would be greatly appreciated.

Sincerely, _____
Project Owner/Management Agent

RETURN THIS FORM TO:

TO BE COMPLETED BY PHYSICIAN or QUALIFIED HEALTH PROFESSIONAL:

The above named individual has a diagnosed physical or mental condition that substantially impedes his/her ability to live independently. Due to this condition, a live-in aide is essential to his/her care and well-being: ☐ Yes ☐ No

The live-in aide is needed:
☐ Full-time ☐ Part Time
☐ Short Term (less than 6 months)
☐ Long Term (more than 6 months)

Physician/Health Professional Name (please print: _____

Address _____

_____

Phone _____

Comments _____

_____

Signature: _____ Date: _____

Note: Title 18, Section 1001 of the United States Code, states that a person who knowingly and willingly makes false or fraudulent statements to any department or agency of the United States or the Department of Housing and Urban Development is guilty of a felony.